UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

March 19, 2013

The Honorable Theresa W. Conroy
Connecticut State Representative
105th Assembly District
Legislative Office Building, Rooom 4113
Hartford, CT 06106-1591

Dear Representative Conroy:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] appreciate the opportunity to respond to your invitation for comments on the likely competitive impact of Connecticut House Bill 6391 ("the Bill" or "HB6391").[2] Current Connecticut law requires that an Advanced Practice Registered Nurse ("APRN") have a collaborative practice arrangement with a physician before the APRN may offer health care services within his or her established scope of practice. No written agreement is required, unless the APRN will be prescribing medications. The Bill would remove the collaborative practice requirement and allow APRNs to diagnose, treat, and prescribe medications for their patients in accordance with their licensed scope of practice without a collaboration arrangement or agreement with a physician.

Recent reports by the Institute of Medicine ("IOM") have identified a key role for advanced practice nurses in improving the delivery of health care.[3] The IOM, established in 1970 as the health arm of the National Academy of Sciences, provides expert advice to policy makers and the public and has conducted an intensive examination of issues surrounding advanced nursing practice. Among other things, the IOM found that advanced practice nurses play a key role in improving access to health care and that "[r]estrictions on scope of practice . . . have undermined [nurses'] ability to provide and improve both general and advanced care."[4]

Similarly, in December 2012, the National Governors Association (NGA) issued a paper exploring the potential role of APRNs in addressing increased demand for primary care services, particularly in historically underserved areas.[5] The report noted, among its findings and conclusions, that APRNs "may be able to mitigate projected shortages of primary care services [and that e]xisting research suggests that NPs can perform a subset of primary care services as well as or better than physicians."[6]

> nurse performs acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section, and shall collaborate with a physician licensed to practice medicine in this state. In all settings, the advanced practice registered nurse may, in collaboration with a physician licensed to practice medicine in this state, prescribe, dispense and administer medical therapeutics and corrective measures and may request, sign for, receive and dispense drugs in the form of professional samples in accordance with sections 20-14c to 20-14e.[17]

Connecticut law defines "collaboration" as:

> a mutually agreed upon relationship between an advanced practice registered nurse and a physician who is educated, trained or has relevant experience that is related to the work of such advanced practice registered nurse. The collaboration shall address a reasonable and appropriate level of consultation and referral, coverage for the patient in the absence of the advanced practice registered nurse, a method to review patient outcomes and a method of disclosure of the relationship to the patient. Relative to the exercise of prescriptive authority, the collaboration between an advanced practice registered nurse and a physician shall be in writing and shall address the level of schedule II and III controlled substances that the advanced practice registered nurse may prescribe and provide a method to review patient outcomes, including, but not limited to, the review of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures that the advanced practice registered nurse may prescribe, dispense and administer.[18]

Thus, current law does not require an APRN to have a formal *written* collaborative practice agreement unless the APRN wishes to prescribe medications. Nonetheless, even APRNs who do not choose to prescribe medications must have a physician willing to be identified by name and practice as a collaborator in order to practice to the full extent of their training, education, and abilities. Although collaborative agreements could, in theory, encompass varying arrangements, the IOM Report observes that Connecticut law imposes no requirements for on-site supervision of APRNs, the frequency or extent to which physicians must review the charts of APRN patients, or the maximum number of APRNs with whom a physician may have collaborative arrangements.[19]

III. LIKELY COMPETITIVE BENEFITS OF HB6391

FTC staff recognize that certain professional licensure requirements are necessary to protect patients. Consistent with patient safety, however, we urge legislators to also consider the potential benefits of competition, including improved access to care, lower costs, and increased options, that the passage of HB6391 would likely promote by removing restrictions on APRNs' ability to practice to the full extent of their training, education, and abilities.

practice authority for APRNs, Connecticut may benefit from a growth in the number of APRNs.

In sum, the Bill's elimination of the collaborative practice agreement requirement for APRNs may improve access and consumer choice for primary care services, especially for rural and other underserved populations.

b. HB6391 Would Likely Lower Costs and Increase Consumer Options

HB6391, which would remove the requirement that APRNs have a collaborative agreement with a physician, also is likely to reduce the cost of basic health care services and could spur innovation in health care delivery and broaden the range of choices available to consumers. APRN care is generally less expensive to patients and payers than physician care, and is often provided in a variety of health care delivery settings.[31] Similar to the situation in other states, there is anecdotal evidence suggesting some Connecticut APRNs who wish to set up a practice that is separate from a physician or other health care entity (*e.g.*, they are not employees) must pay physicians to enter a collaborative agreement.[32] Unless these arrangements involve true and beneficial supervision,[33] they raise the possibility that APRNs are *not* compensating physicians for their time, but rather for the potential loss of income some physicians believe may occur as a result of APRNs' entry into the primary care marketplace. Such payments raise the costs of practice, likely resulting in fewer independently practicing APRNs and higher prices, without any improvement in the quality of care provided.

The Connecticut Coalition of Nurse Practitioners, in a formal request for review and expansion of APRNs' scope of practice made to the Department of Public Health, provided five specific case examples of APRNs' difficulties in identifying physicians willing to collaborate.[34] These case examples illustrate several issues of concern. First, securing a collaborative practice agreement may be a difficult process for some APRNs. Some APRNs who attempted to use the Connecticut State Medical Society's "APRN Assist" link to find a physician collaborator did not receive any response or were told there were no physicians "hiring" at that time, even though the APRN explained she was not looking for a job, but for a collaborator.[35] Second, APRNs may find it difficult and costly to develop a sustainable business with this requirement in place. Even if they find a physician who is able and willing to agree to collaborative practice, the APRN may not be able to find a substitute if a collaborating physician retires, relocates, passes away, or just decides to revoke or refuse to renew the collaborative practice agreement.[36] Finally, the case examples suggested one APRN had to pay a collaborating physician 70 percent of her reimbursement and another APRN had to pay $30,000 per year to the collaborating physician.[37]

APRNs have also played an important role in the development of alternative settings for care delivery, such as retail clinics. Retail clinics typically are located within larger retail stores, staffed by APRNs, and offer consumers a convenient way to obtain basic medical care at competitive prices.[38] Retail clinics generally offer weekend and evening hours, which provide greater flexibility for patients,[39] and appear to provide

IOM, as well as the literature review and conclusions of the National Governors Association. Maintaining an unnecessary and burdensome requirement is likely to deprive consumers of the benefits that increased competition can provide. Therefore, the Connecticut legislature should carefully consider the safety record of APRNs in Connecticut. Absent countervailing safety concerns regarding APRN practice, HB6391 appears to be a procompetitive improvement in the law that would benefit Connecticut health care consumers.

Respectfully submitted,

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Richard A. Feinstein, Director
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[1] This staff letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. The letter does not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. The Commission, however, has voted to authorize staff to submit these comments.

[2] Letter from the Hon. Theresa W. Conroy, Connecticut House of Representatives, to Andrew I. Gavil, Director, Office of Policy Planning, Federal Trade Commission (rec'd Feb. 7, 2013) [hereinafter Letter from Rep. Conroy].

[3] *See generally* INSTITUTE OF MEDICINE, THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH (2011) [hereinafter IOM NURSING REPORT] (especially Summary, 1-15).

[4] *Id.* at 4. *See also id.* at 85-161, 98-99 (discussing nursing scope-of-practice issues and quality of care, including numerous quality of care studies); About the Institute of Medicine, *available at* http://www.iom.edu/About-IOM.aspx.

[5] National Governors Association, *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care* (Dec. 20, 2012), at: http://www.nga.org/cms/home/nga-center-for-best-practices/center-

[15] FTC and staff advocacy may comprise letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. *See, e.g.*, Letter from FTC Staff to Hon. Timothy Burns, Connecticut Legislature, (May 1, 2009) (regarding proposed restrictions on mobile dentistry), *available at* http://www.ftc.gov/os/2009/05/V090009Connecticutdentistry.pdf; FTC and DOJ Written Testimony before the Illinois Task Force on Health Planning Reform Concerning Illinois Certificate of Need Laws (Sept. 2008), *available at* http://www.ftc.gov/os/2008/09/V080018illconlaws.pdf; FTC Amicus Curiae Brief in *In re Ciprofloxacin Hydrochloride Antitrust Litigation* Concerning Drug Patent Settlements Before the Court of Appeals for the Federal Circuit (Case No. 2008-1097) (Jan. 2008), *available at* http://www.ftc.gov/os/2008/01/080129cipro.pdf; FTC & DOJ, IMPROVING HEALTH CARE *supra* note 14.

[16] FTC Staff Testimony Before Subcommittee A of the Joint Committee on Health of the State of West Virginia Legislature on The Review of West Virginia Laws Governing the Scope of Practice for Advanced Practice Registered Nurses and Consideration of Possible Revisions to Remove Practice Restrictions (Sept. 2012), *available at* http://www.ftc.gov/os/2012/09/120907wvatestimony.pdf; FTC Staff Letter to The Hon. Thomas P. Willmott and The Hon. Patrick C. Williams, Louisiana House of Representatives, Concerning the Likely Competitive Impact of Louisiana House Bill 951 Concerning Advanced Practice Registered Nurses (Apr. 2012), *available at* http://www.ftc.gov/os/2012/04/120425louisianastaffcomment.pdf; FTC Staff Letter to The Hon. Paul Hornback, Senator, Commonwealth of Kentucky State Senate Concerning Kentucky Senate Bill 187 and the Regulation of Advanced Practice Registered Nurses (Mar. 2012), *available at* http://www.ftc.gov/os/2012/03/120326ky_staffletter.pdf; FTC Staff Letter to The Hon. Rodney Ellis and The Hon. Royce West, the Senate of the State of Texas, Concerning Texas Senate Bills 1260 and 1339 and the Regulation of Advanced Practice Registered Nurses (May 2011), *available at* http://www.ftc.gov/os/2011/05/V110007texasaprn.pdf; FTC Staff Letter to The Hon. Daphne Campbell, Florida House of Representatives, Concerning Florida House Bill 4103 and the Regulation of Advanced Registered Nurse Practitioners (Mar. 2011), *available at* http://www.ftc.gov/os/2011/03/V110004campbell-florida.pdf.

[17] CONN. GEN. STAT. § 20-87a (2012). The Connecticut Department of Public Health is responsible for issuing licenses to nurses, CONN. GEN. STAT. § 20-92 (2012) and to APRNs, CONN. GEN. STAT. § 20-94 (2012). The Connecticut State Board of Examiners for Nursing consults with the Department of Health concerning licensure examinations for licensed practical nurses and registered nurses. CONN. GEN. STAT. § 20-90a (2012). In addition, "the [nursing] board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints filed against practitioners licensed under this chapter and impose sanctions where appropriate." CONN. GEN. STAT. § 20-90b (2012). CONN. GEN. STAT. § 20-94a (2012) states:

> The Department of Public Health may issue an advanced practice registered nurse license to a person seeking to perform the activities described in subsection (b) of section 20-87a, upon receipt of a fee of two hundred dollars, to an applicant who: (1) Maintains a license as a registered nurse in this state, as provided by section 20-93 or 20-94; (2) holds and maintains current certification as a nurse practitioner, a clinical nurse specialist or a nurse anesthetist from one of the following national certifying bodies that certify nurses in advanced practice: The American Nurses' Association, the Nurses' Association of the American College of Obstetricians and Gynecologists Certification Corporation, the National Board of Pediatric Nurse Practitioners and Associates or the American Association of Nurse Anesthetists, their successors or other appropriate national certifying bodies approved by the Board of Examiners for Nursing; (3) has completed thirty hours of education in pharmacology for advanced nursing practice; and (4) if first certified by one of the foregoing certifying bodies after December 31, 1994, holds a master's degree in nursing or in a related field recognized for certification as either a nurse practitioner, a clinical nurse specialist, or a nurse anesthetist by one of the foregoing certifying bodies.

[18] CONN. GEN. STAT. § 20-87a (2012). It is our understanding under current law that although an APRN must have a collaboration agreement with a physician in order to practice independently, the agreement must only be in writing if the APRN will be prescribing medications.

[30] *See, e.g.*, TEXAS LEGISLATIVE BUDGET BOARD STAFF, TEXAS STATE GOVERNMENT EFFECTIVENESS AND EFFICIENCY: SELECTED ISSUES AND RECOMMENDATIONS 297, 300 (Jan. 2011) (submitted to the 82nd Texas Legislature) (indicating that the number of advanced practice nurses is lower in states with restrictive regulatory environments, and these restrictions may "limit the expansion of retail clinics, which generally employ APRNs to provide a limited range [of] primary healthcare") [hereinafter TEXAS BUDGET BOARD STAFF REPORT]; Julie A. Fairman et al., *Perspective: Broadening the Scope of Nursing Practice*, 364 N. ENGL. J. MED. 193, 194 (2011) (noting "nurses tend to move from more restrictive to less restrictive states . . . with a resulting loss of access to care for patients").

[31] *See* Joanne M. Pohl et al., *Unleashing Nurse Practitioners' Potential to Deliver Primary Care and Lead Teams*, 29 HEALTH AFFAIRS 900, 901 (2010), *available at* http://content.healthaffairs.org/content/29/5/900.full.pdf+html (noting APRNs and physicians assistants are underutilized "despite being qualified to provide primary care at a lower cost than other providers").

[32] See CT APRN Coalition's Request for Scope of Practice Change, *supra* note 7 at 8. Anecdotal evidence from other states suggests APRNs pay significant fees to collaborating physicians. *See, e.g.*, Letter from The Hon. Paul Hornback, Commonwealth of Kentucky State Senate, to Susan DeSanti, Director, Office of Policy Planning, Federal Trade Commission (Jan. 18, 2012) (noting in "some cases, the physicians are charging a considerable amount of money monthly or annually to sign a CAPA [the collaborative prescribing agreement], although they essentially perform no services for the fee"); Letter from The Hon. Thomas P. Willmott and The Hon. Patrick C. Williams, Louisiana House of Representatives, to Susan S. DeSanti, Director, Office of Policy Planning, Federal Trade Commission (Jan. 18, 2012), (noting that APRNs in Louisiana often must pay 10-45% of their collected fees to physicians for entering into collaborative practice agreements).

[33] *See* discussion in Section II *supra* at note 19 and accompanying text.

[34] CT APRN Coalition's Request for Scope of Practice Change, *supra* note 7 at 8.

[35] *Id.* at 8 (Case #1 and Case #2).

[36] *See Id.* (Case #1).

[37] *Id.* (Case #4 and Case #5); *see also supra* note 32 and citations therein.

[38] *See* Robin Weinick, et al., *Policy Implications of the Use of Retail Clinics* at 12 (2010) (Rand Health Technical Report prepared for the U.S. Dept. of Health and Human Serv.), at http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR810.pdf [hereinafter Rand, *Policy Implications of the Use of Retail Clinics*] (also noting the services offered at retail clinics are generally narrower in scope than those provided by urgent care centers and emergency rooms); Ateev Mehrotra et al., *Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison of Patients Visits*, 27 HEALTH AFFAIRS 1272, 1279 (2008). *See generally* William M. Sage, *Might the Fact that 90% of Americans Live Within 15 Miles of a Wal-Mart Help Achieve Universal Health Care?*, 55 U. Kan. L. Rev. 1233, 1238 (2007) (describing the size and scope of retail clinics); Mary Kay Scott, Scott & Company, *Health Care in the Express Lane: Retail Clinics Go Mainstream*, at 22 (Sept. 2007) (report prepared for the California HealthCare Foundation), *available at* http://www.chcf.org/publications.

Evidence indicates that the quality of care provided by APRNs in retail clinics is "similar to that provided in physician offices and urgent care centers and slightly superior to that of emergency departments." Ateev Mehrotra et al., *Comparing Costs and Quality of Care at Retail Clinics with that of Other Medical Settings for 3 Common Illnesses*, 151 ANNALS INTERNAL MED. 321, 326 (2009) (analyzing 14 quality metrics for commonly treated ailments, including ear, strep, and urinary tract infections, and finding "[f]or most measures, quality scores of retail clinics were equal to or higher than those of other care settings").

[39] *Cf.* Rena Rudavsky, Craig Evan Pollack, & Ateev Mehrotra, *The Geographic Distribution, Ownership, Prices, and Scope of Practice at Retail Clinics*, 151 ANNALS INTERNAL MED. 315, 317 (2009) ("In a